

JUN 5 1922

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# THE RHODE ISLAND MEDICAL JOURNAL



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VOLUME V    { Whole No. 153

PROVIDENCE, R. I., JUNE, 1922

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The Official Organ of the Rhode Island Medical Society  
Issued Monthly under the direction of the Publication Committee

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## ORIGINAL ARTICLES

### SIGNIFICANCE OF BLADDER SYMPTOMS IN WOMEN.\*

BY DR. ERIC STONE AND DR. JAMES McCANN  
PROVIDENCE, R. I.

This paper is the result of certain theories concerning out-patient work which Dr. McCann has held since an investigation of similar work in clinics of other cities was carried on by him some years ago at the instigation of the Gynecological Staff of the Rhode Island Hospital. He felt that the out-patient service, as well as the individuals conducting it, would benefit if each member, besides carrying on the routine procedure of his department, made a study of some special phase of that work. Accordingly, we decided to make a more careful out-patient study of women with bladder symptoms than had formerly been carried on. This has been done with the accumulation of 63 unselected cases, taken as they presented themselves at the clinic. These cases have been given as thorough a gynecological and urological examination as possible. This included physical examination; chemical, microscopic and bacteriological examination of the urine; and cystoscopy in all cases; ureteral catheterization in 39 cases, pyelography in 12, and genito-urinary plates in 18 other cases. The ureteral catheterization involved in each case microscopic examination of the divided urines, with necessary cultural and staining methods of bacteriological diagnosis, and a determination of the divided renal function.

While nothing particularly new or novel has emerged from the study, certain general principles may be stressed which are of interest to the practitioner, the gynecologist and those interested in out-patient work. 1st. Of the 34 cases presented with a diagnosis already made, 38% were incorrect because of lack of urological examination. 2nd. One in five were presented as a cystitis when

the bladder symptoms masked a more important condition in the upper urinary tract or in the pelvis. 3rd. Urological examination saved five patients a surgical attack on appendix or tubes or normal ureter. 4th. The importance of the cystoscope in the armamentarium of the gynecologist is clearly shown; and finally, the feasibility of this work in office or out-patient department is demonstrated.

The symptoms to be discussed are arbitrarily fixed as follows: 1. Pain in the region of the bladder; 2. Frequency and burning of micturition; 3. Sense of a residual urine; 4. Retention of Urine; and 5, Incontinence of urine.

Twenty-seven of the cases in our limited series complained of pain in the region of the bladder. In 18 of these, cystoscopic examination revealed marked changes in the trigone, including elevation, hyperaemia, cystic oedema or combinations of these. In seven the pain was preliminary, in nine it was terminal, in two it was sensed throughout the act, while in nine it was constant, lasting up to or nearly to the next micturition. Of those complaining of preliminary pain, the chief lesion was trigonitis in five and acute urethritis in two. When the pain was terminal, there was a greater diversity of etiology; four presented ulcers in the urethra near the sphincter, three had a generalized chronic cystitis, one suffered from acute urethritis and the last was a case of submucous ulcer.

These findings are readily explained by a study of the anatomy and physiology of the bladder, especially of the trigone and the sphincter. The trigone forms the floor of the bladder when the woman is in the upright position and is morphologically similar to a funnel, carrying the urine from the vesicle fundus to the urethra. It is a group of muscle bundles continuous with the muscle fibers of the ureters and streaming down from either ureter, intermingling in the midline and passing to the urethra inside the internal sphincter on the sphincter's posterior segment. The trigone is laid on the normal bladder musculature and may be lifted bodily from it. Nerve ganglions and sympathetic fibers are present in the trigonal muscles, while the bladder wall is supplied by sym-

\*From a clinical study of selected cases in the Gynecological Out-Patient Department of the Rhode Island Hospital. Read before the Providence Association March 6, 1922.

pathetic and parasympathetic fibers, which probably explains why the trigone is the most sensitive part of the bladder. In spite of the prevailing belief to the contrary, micturition does not take place through the inhibitory action on the sphincter. It is brought about by a contraction of the trigone, which passing as it does through the less powerful muscles of the sphincter, pulls these weaker arcuate fibers apart<sup>7</sup>. The flow of urine then follows under the pressure of the contracting bladder muscles, aided by voluntarily increased intraabdominal pressure. The response of this structure to infection is oedema, hyperaemia and infiltration with leucocytes.

It is not then surprising that five out of seven cases complaining of pain at the onset of micturition showed a stiff, oedematous trigone, which gave severe pain when powerfully contracting to open the vesicle neck. The other two cases had acute urethritis with inflamed walls that were sensitive to the passage of foul, acid urine.

The same correspondence is seen between symptomatology and physiology in the cases having pain at the end of micturition. Four had ulcers of the urethra so close to the sphincter that they were pinched in the contraction of the released internal sphincter at the cessation of flow. In all the other cases, save that of submucous ulcer, there was present a generalized cystitis which the muscles of the bladder wall traumatized while contracting and the approximated surfaces of which were sensitive when brought into apposition on emptying the bladder.

Thus it is seen that the pus in the urine is not the cause of the pain, which is due to inflammatory changes in the bladder structures, most frequently in the trigone.

#### FREQUENCY AND BURNING.

Twenty-two cases entered with the chief complaint of frequency and burning on micturition. All but three of these cases had marked changes in the trigone. One of the cases in which the trigone was normal was an early acute gonorrhreal urethritis, while another was a case of acute streptococcus pyelonephritis, with marked reflex bladder symptoms; but too early for noticeable changes in the bladder. The third was a case of nephropathy with intermittent hydronephrosis, cystoscoped in an interval between attacks.

In 14 of these cases there was no local or gen-

eral infection of the fundus of the bladder. The symptoms were dependent on the irritation of urine in contact with the inflamed, sensitive and intolerant trigone. These observations are made understandable by again turning to the morphology and physiology of the trigone and its vicinity. The trigone is the most actively functioning part of the bladder and so has the least opportunity to rest when infected. Indeed, the irritability produced by the inflammation increases its activity. This hyperfunction would tend to aggravate and keep active any infection in the region of the trigone and presents a partial explanation of the high trigonal morbidity. Furthermore, the mucosa of the trigone is without a submucosa such as is found in the rest of the bladder; and there are many layers of epithelial cells instead of the three layers in the mucosa of the fundus. This prevents the free movement of the mucosa over the moving muscles, so subjects the mucosa to more trauma than is suffered by that of the fundus. Moreover, the larger vessels of the blood supply of this viscous enter at the bladder neck, and in the female at this region are the important anastomoses with the uterine and vaginal vessels. There are two sets of lymphatics in the bladder, one in the mucosa and one in the muscularis, the former being particularly developed in the trigone. While it would seem that this would enhance rather than impede recovery from infection, this is not the case. The engorgement of the vessels and the blocking of the lymphatics found in the region of any infection occurs in this area also and leads to a relative or complete obstruction which increases the oedema of the trigone. Furthermore, the position of the trigone favors infection. The urine from the kidneys is poured onto it, even when supine if the body is at rest sediment falls onto the trigone, and when the bladder is only partially filled the trigone is covered by the largest amount of urine, the mucosa of the fundus being protected by folding on itself. Somewhat in corroboration of this is the finding of the signs of marked infection or chronic infection, such as oedema and polyps, is most frequent in the trigone. In our series four polyps were found, all of them occurring on this structure. In short, it is plausible to assume that the trigone is more susceptible to infection than the other parts of the bladder.

The fact of anastomoses with the uterine and vaginal vessels explain the appearance of the symptoms under discussion in women where there is no infection in the bladder or in any part of the urinary tract. In the present group of cases eight such cases were seen. These included four of endocervicitis, two of chronic pelvic inflammation and two of varicose veins of the broad ligaments, in one of which there was a pelvic phlebitis. While in the cases of chronic pelvic inflammation there may have been an element of irritation of the neighboring muscularis and mucosa, yet it was so mild that there was no sign of inflammation to be seen on the inside of the bladder. So it seems fair to at least suggest that the bladder symptoms were caused by the participation the bladder vessels took in the engorgement of the pelvic vessels. Indirect support of this view is found in the fact that in eight of the cases discussed in this and the next two paragraphs an increase in vesicle symptoms was observed at the approach of the menses.

Another cause of frequency and burning, as well as its underlying cause, trigonitis is illustrated by those cases having marked cystocele. We had the opportunity of observing four of these. The trigone is carried down and back so that its muscles work at a mechanical disadvantage. The ureters are also drawn down and this traction and torsion may result in partial ureteral obstruction<sup>2</sup>. In one case a pyelitis resulted from this ureteral urinary stasis and in a second the dragging was so marked that the ureteric orifices faced backward and could not be catheterized.

In two cases the cervix of a uterus which was retroverted but not also retroflexed was seen to press up on the trigone and cause by its elevation not only oedema of that structure but sacculation of the bladder. In another case a large fibroid of the uterus not only limited the capacity of the bladder but because of the share the trigone vessels took in the general pelvic congestion it produced such oedema of the trigone that at the time of the menses there was complete retention which necessitated catheterization of the bladder. In this case there were no leucocytes in the urine and the urine was sterile.

The effect of the pregnant uterus on the bladder is too well known to require discussion of the two cases which consulted us for the relief of this

pressure cystitis. In neither of these cases did it happen that the condition was purely mechanical, for in one there was a symptomless pyelitis on one side with mild infection of the bladder urine; and the other had a gonorrhreal urethritis and cystitis. In both cases the trigonitis, that our hypothesis of its basis in part in concomitant pelvic engorgement would lead us to expect, was a prominent feature of the bladder picture.

In several instances in discussing the etiology of bladder symptoms reference has been made to pyelitis. Of 18 cases of pyelitis found in this series seven were accidentally found in routine urological examinations, as the condition was entirely masked by the bladder symptoms. With these may be mentioned three cases of tuberculosis of the kidney, in only one of which was there any pain in the kidney region. The most marked symptoms in these cases were those associated with the bladder infection; the two others presenting bladder symptoms alone. The period between the onset of symptoms and correct diagnosis is of interest as it illustrates the error gynecologists may fall into when gynecological examination alone is depended on. In one the period was 10 years, in another four years, and in the last, four months.

Four of the cases of pyelitis were bilateral and in each case associated with a marked chronic cystitis; the bladder symptoms alone were present in three of the four, in the other there was occasional pain in the region of the kidneys. In one the bladder symptoms had been present intermittently for 20 years and constant for 10. The others showed a period of morbidity of four, three and two years. The point of interest is that they all had received bladder treatments throughout these periods with no attempt at kidney examination.

Fourteen of the pyelitis cases were one-sided. Eight of these showed some cause for permanent or temporary urinary stasis on the affected side. Three had marked ptosis, two passable ureteral strictures (right-sided in the normal iliac constriction of the ureter), in one a stone obstructed the flow of urine. Pregnancy accounted for the obstruction in one. Possible causes of temporary stasis were found in two others, i. e., marked cystocele and chronic salpingitis on the affected side. These findings are of interest in relation to a recent article by Crabtree and Shedd<sup>3</sup>. These

authors point out that pyelitis is a chronic condition usually finding its source in some acute kidney infection which resolves itself into a simple infection of the pelvis. Their important contribution is the explanation of the fact that so often only one kidney is involved or if both are acutely infected only one has a persistent pyelitis. They conclude from a study of a large series of cases that the determining factor is urinary stasis. The most frequent cause is nephroptosis; even when it is so slight that drainage is free part of the day so that hydro- or pyonephrosis does not develop.

In view of this and the frequent masking of the pyelitis by the cystitis it causes and of the frequent occurrence of nephroptosis in women (22%, as compared with 2% in men)<sup>1</sup>, this subject is important to the gynecologist. The reason of this preponderance in the female is that in women the kidney bed is shallow, and more open than in men. The important adjunct of abdominal tonicity and its resulting interabdominal pressure is lacking in part due to pregnancy, use of corsets, and lack of exercise. The most typical type of case is in the thin, anaemic woman with poor fat deposits, whose tendency to kidney ptosis is further increased by poor development of the fatty capsule of this organ. Another type of case is the stout woman with a heavy caecum pulling the kidney down by traction on the nephrocolic ligament.<sup>2</sup>

#### SENSE OF RESIDUUM.

Six of the cases seen by us in this series were troubled by a sense of residual urine. Five of these had a highly infected urine. In two cases a cystocele was present as part of a lacerated perineum and relaxed pelvic floor. One of these patients had made the interesting observation that by pressing on the anterior vaginal wall with her hand at the end of micturition a little more urine was expressed and this annoying symptom was headed off. In two others oedema of the trigone was sufficiently marked to cause sacculation of the bladder and prevent its complete emptying. A fifth case was that of gonorrhreal cystitis complicated by pregnancy. The last of the group had a stricture of the bladder. In short, this symptom is easily explained on mechanical grounds, and its acuteness is increased by infection of the residual urine.

#### INCONTINENCE AND RETENTION.

Incontinence and retention of urine, unless caused by central nervous system lesions, none of which occurred in this series, is easily also explained on mechanical and anatomical grounds. Only two of our cases were troubled by retention. One was the case of fibroid uterus with marked hypertrophy of the trigone, which was discussed in an earlier paragraph. The other case was that of urethral stricture which caused obstruction enough to make micturition difficult at all times and cause retention at those times when increased inflammation or congestion completed the obstruction.

Incontinence is a subject of considerable importance to the gynecologist as it is so frequent an accompaniment of cystocele and follows many operations for repair of the anterior vaginal wall. Four of the cases under discussion had marked cystocele, only two of which complained of incontinence. Both of these in cystoscopy showed a widely relaxed sphincter. Our examinations were done with the far vision cystoscope so that the condition of the urethra was not determined. Young has observed in similar cases that the dorsal wall of the urethra shares in this relaxation and becomes longer and is ballooning<sup>3</sup>. It takes a horizontal position and loses the support of the tissues in the triangular ligament. This atonicity permits an escape of urine on sneezing, coughing or jouncing. In one of our cases the patient had a markedly contracted bladder dependent on a cystitis of 15 years standing and augmented by scarring following two vesicle operations. The result was an incontinence due to overflow, the bladder permitting escape of fluid as soon as 30 cc. of urine had collected. The fourth case was similar, being that of the girl with gonorrhreal cystitis and a pregnant uterus which limited the capacity to 60 cc. Again, then we have met a symptom based on mechanical factors, with infection playing a part of but secondary importance.

If from so small a series of cases any deductions are permissible, they are as follows:

1. The short urethra, poorly supported posterior wall of the bladder, proximity of vagina, cervix, uterus and tubes all liable to infection, the possibility of tumor formation in the uterus, cervix and ovaries, anastomoses with uterine and

vaginal vessels, and tendency to nephroptosis and kidney infection tend to make the bladder of women an organ peculiarly prone to urinary stasis and infection.

2. The proximity of the above structures and the pathological processes in them often set up a series of urinary symptoms which make differential diagnosis difficult.

3. Bladder symptoms are in many cases a mask of more important conditions which are extravescicle, in some even entirely outside the genitourinary tract.

4. Symptoms are not so much produced by the original infecting process as by pathologically changed structures which produce the symptoms mechanically, as the stiff oedematous trigone, the ptotic kidney, the cystocele or the enlarged uterus.

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#### THE TREATMENT OF EAR INFECTIONS IN CONTAGIOUS DISEASES.\*

By JOHN J. GILBERT, M.D.

PROVIDENCE, R. I.

All members of the profession, and particularly those interested in otology, are aware of the incidence of middle ear infection in the course of the acute infectious diseases of childhood. In the long discharging ears of adults, a careful history shows, in most cases, that the original ear infection began during one of the exanthemata of childhood.

In many of these cases, the ear discharged continuously; some have discharged periodically; and the neglected cases show extensive destruction of drum membrane and ossicles. When polypi and cholesteatoma are present in addition, the ear becomes a very dangerous one, and besides the loss of hearing that results, a radical mastoid with its

dangers, difficulties, and disadvantages, is necessary often to save life.

In a survey of what is done to prevent this common type of ear trouble in our best contagious hospitals, we found that little effort was expended to correct these unfortunate results following acute middle ear disease from the exanthemata.

As a rule, an acute otitis media, developing during one of the contagious diseases is promptly incised, when recognized early, or ruptures spontaneously, if unrecognized. The ear is then irrigated or wicked frequently and general attention (rest, liquids, catharsis, etc.) is carried out. When the pain and temperature subside, and the discharge decreases, little attention beyond this routine treatment is given to the ear condition. In spite of this routine, often poorly executed, a certain large proportion heal spontaneously, while many continue to discharge mildly, and attention is diverted to the heart, lungs and kidneys, for the feeling prevails that a discharging ear, without temperature, tenderness, and edema takes care of itself, and that attention should go to watching for and treating other complications of the disease. It is neglect of the ears at this time that probably paves the way for many of these serious discharging ears of adult life.

It seems well founded that in such diseases as scarlet fever and measles, that the progress of destruction of ear tissues is very rapid, and when fulminating mastoid signs develop, operation is fortunately done promptly. Rarely do we find this type of ear, in which simple mastoid was necessary, among the chronic discharging ears of adult life that come to us.

Our investigation tends to show that cases requiring operation leave the hospital with dry ears and much saving of ear structure, and fare better than the cases that drag along with mild discharge.

It is our purpose to show that all ears that continue to discharge after four weeks, without other visible signs of mastoid involvement, need conservative operative treatment, regardless of the infection, but this should be particularly early and prompt in ears of contagious origin.

In general practice, even less is done than in the hospitals to follow these acute ears. After the acute stage has passed, the discharge is allowed to continue because it is inoffensive and is consid-

\* Read before the R. I. Ophthalmological and Otological Society December 13, 1921.

ered in rather a light way by physicians in general. To illustrate, a young, well-trained surgeon, in discussing chronic suppurating otitis media, told me that he seldom saw any trouble from this type of ear. He had known many people who had such ears for years, and except for the discomfort of cleansing them, the occasional odor, and some loss of hearing, they were none the worse for them. When an opinion of that type, and we hear it often, is forthcoming from men of standing in the profession, what an insignificant place these ears have with the medical men in general. We, the otologists, know that complications from these ears in later life are as serious as those of heart, lungs, kidneys, or any other complication of contagious disease that would tend to invalid the patient, or cause his sudden demise. Cases of meningitis, brain abscess, facial paralysis, or sinus thrombosis, resulting from these ears and requiring serious operations, may be rare in any one man's practice, but in a large ear clinic, they are common, and someone has likened these ears to a gasoline tank exposed to a constantly present flame, in that it is unknown when the flare up will come. This is especially true where irrigations and swimming are indulged in.

From still another standpoint, though secondary in importance to saving hearing and life, these ears that continue to discharge for weeks and weeks after the time for normal healing has passed, become a burden to the municipal contagious hospital. That they are a source of infection in spreading these diseases is certain. Accordingly, these patients must be kept isolated for a long time, when other factors of the disease have cleared up. This does not hold true in measles, in which disease the discharging ear or nose does not seem to transmit the infection, except in the first few days of the disease. It is particularly true, however, in scarlet fever and diphtheria.

One case of scarlet fever at the City Hospital, with suppurating otitis media, in which the ear discharged five months, was sent home. In a short time, other members of the same family were admitted with the same disease. When the discharge becomes non-infectious with the possible exception of diphtheria, cannot be determined, but in scarlet fever it is very long. An early healing is desired then to prevent the spread

of the disease and lessen the stay in the hospital as well as to preserve hearing and health.

It is generally believed that ear infection in contagious disease is so virulent at times that a great deal of destruction to tissue ensues in the first few days. Also, that the severe toxemia rapidly affects the auditory nerve, and hearing is blotted out in the beginning. That this takes place in some cases cannot be denied. It has not been my experience to see many such cases and I believe that they are few as compared to cases that arrive at the same condition from long continued discharge and neglect. Even this fulminating type would probably be rendered dry and less dangerous by an early simple mastoid operation. If this did not dry up the ear, and a radical operation became necessary later on, part of the work has been accomplished thereby and time saved.

To cope with middle ear infections in contagious diseases at the Providence City Hospital, the following plan was worked out with Doctor F. N. Bigelow, Chief of the Aural Service, and Doctor D. L. Richardson, Superintendent. All cases of acute otitis media developing in the contagious wards are incised promptly. If they rupture spontaneously, they are also incised, as such an opening is seldom adequate for drainage, and results in sloughing of a large area of drum membrane, which is replaced in healing by less resisting scar tissue with adhesions. The ear is then irrigated or wicked frequently, and kept as clean as possible. General treatment is added (fluids, ice-bag, rest, etc.). Unless mastoid signs appear, this routine is kept up for about two weeks. If there is a free discharge after that time, in spite of ample drainage and care, the adenoid tissue and tonsils are removed, the belief holding that much of the infection rests in the large adenoid tissue and tonsils in these cases. Since it takes about a week for the resulting blood clot in the nasopharynx to resolve, no great improvement could be expected before that time. Hence, the ear treatment is kept up during this interval, and the amount and character of the discharge is observed carefully during the next (fourth) week. If free pus continues then, a simple mastoid operation is performed. If the discharge lessens and becomes mucoid in character after adenoid removal, a little longer time is allowed for healing.

This time schedule is not adhered to closely, and may be varied according to the individual case, i. e., (the type and location of perforation, the character of the discharge, and rapidity of destruction, etc., being considered). It is outlined to show that these ears have been well cleaned up by following such a plan. That they may discharge for a longer time and still be checked by simple mastoid operation is shown in the following cases of this short series.

Case 1544, A. D., 5½ years old. Diagnosis: scarlet fever. Admitted March 24, 1921. Both ears discharging freely through large central perforations; no tenderness or edema over mastoid. The ears continued to discharge in spite of routine treatment, and on April 12th, tonsils and adenoid were removed. There was no improvement noted, and on April 29th, a double simple mastoid operation was performed. On May 24th, less than a month later, the patient was discharged with dry ears and mastoid healed.

Case 15824, R. K., 4½ years. Diagnosis: scarlet fever. Admitted July 2, 1921. Three months previous to admission, patient had scarlet fever and both ears discharged. The left healed spontaneously, but the right continued to discharge. Tonsils and adenoid were removed cleanly one month before admission with no change in discharge from right ear. There was no swelling, tenderness, or other mastoid signs aside from the discharge. July 3, 1921, right simple mastoid operation; July 12th, right ear dry and mastoid wound closing rapidly. Patient was discharged from the hospital on July 14th with ear well. This discharging ear was of three months' standing, and showed no tendency to heal, until mastoidectomy was done.

Phillips, Hays, Dench and a score of other otologists have emphasized strongly the value of a simple mastoid operation to terminate a discharge and save hearing in those ears that fail to heal promptly after a few weeks of discharge, whether or not other signs of mastoiditis were present.

Because of the destructive nature of infection in contagious disease, I believe intervention should come even earlier than they have advised; when the discharge is mucoid in type, adenoid removal will often suffice, and should be tried first in all types, but when free pus continues in spite of this, no time should be lost in doing a conservative

mastoidectomy. The operation is done often enough where there are acute signs present, but not frequently enough in the subacute types to save hearing, as few can be brought to allow operation on the mastoid, unless there seems a danger to life, with temperature and edema and redness, etc. The public should be educated to the fact that the mastoid operation is most valuable as a hearing-saving device.

Since most of our patients have been children in whom the infantile type of mastoid prevails, there was little else found at operation than the antrum cell, and a few smaller cells scattered about it. Pus or granulations were found in every case in the antrum. The operation is not a formidable procedure in children, if care is taken about the middle ear, where there is danger of dislodging the incus in curetting. In these reported cases, there were no operative complications. The operation can be done rapidly, is followed by very little reaction, and should not be termed a mastoid operation. The public in general are too awe-struck by the term, and frequently the parents refuse permission to operate because of the horror it implies to their minds. It should be termed incision of postaural abscess or postaural incision, or some such term. They will more readily assent to its being done in that event.

The healing has been prompt whenever careful attention has been paid to the post-operative dressings. In one case, in which the ear wick was allowed to buckle in the canal, a pool of pus was present from day to day. Carefully placing the wick so that its tip rested against the drum and changing it frequently, brought about prompt healing. This was a case of long standing and it was thought the simple operation was done too late to effect a healing. When the patients have been old enough, hearing has been tested by whispered voice and found good.

There is little doubt that the simple procedure of removing the adenoid and tonsils is responsible for cleaning up many of these ears, because most of the infected material is in the adenoid and tonsils. Their removal as a routine in these contagious diseases is not far off. Certainly any child that has had measles, scarlet fever, etc., whether the ear has been infected or not at the time, should have these lymphoid structures removed before leaving the hospital for home. These harbor the

infection, even when the ears are uninvolved, and are no doubt responsible for spreading infection as well as causing many chronic catarrhal ears of later life because of the infection that remains dormant in them indefinitely. Occasionally the sinuses are infected and the thought probably comes to you that these are more responsible than the tonsils and adenoid, for the profuse nasal discharge that follows these diseases. It has been our experience that a nasal discharge rarely continues after adenoid removal. We conclude, therefore, that the sinuses are seldom responsible. With the procedure outlined above well carried out, there will be fewer chronic ear cases in adults, both suppurative and non-suppurative. True, a few normal tonsils may be sacrificed by making removal of tonsils and adenoid a rule, but when we consider how unfruitful is the treatment of the chronic catarrhal ear, our best efforts should aim at prevention. We are starting in the right direction when removing tonsils and adenoid, which we know by virtue of having been infected during contagious disease, are an early source of infection for ears, and remain so for a long time.

In 129 cases of otitis media suppurata occurring in the contagious wards of the Providence City Hospital in past two years, eighty cases healed spontaneously under careful routine treatment with no other operative measure than paracentesis, and left the hospital with dry ears. These cases should have had tonsils and adenoid removed before leaving the hospital, I believe, to prevent re-infection of the ears, and I hope we may add this feature to our plan shortly. In sixteen cases, removal of tonsils and adenoid proved sufficient to heal those acute ears that did not yield to routine treatment. Ten cases continued to discharge in spite of tonsillectomy, and in these the simple mastoids were performed. Eight of these cases left the hospital with dry ears within a month of operation. Two were discharged against advice before a month with mild discharge from the ears.

The foregoing procedures account for one hundred and six of the total number. There were nine deaths from other sources in which there were discharging ears. Nine discharging ears were discharged improved where no operative measures were done, before this plan was followed, and five cases were unimproved. No operations. (No permission for operation.)

The cases were distributed as follows: scarlet fever, 49 cases; measles, 37 cases; diphtheria or diphtheria carriers, 34; pertussis, 3; influenza, 2; chicken-pox, 2; erysipelas, 2; total, 129.

The mastoid cases were from the following diseases, scarlet fever 5, diphtheria or diphtheria carriers 2, measles 3. It is hardly fair to test the efficiency of such a plan on so few cases, yet the results thus far have been so encouraging that a preliminary report seemed worth while to stimulate other workers with ears in contagious cases to try out the plan. As yet, we have not found any ears that did not respond well to this treatment. Since this procedure of following up discharging ears will be continued, further reports will be forthcoming, and its true worth will be tested in the event of a very severe epidemic of one of these diseases. It goes without reserve, however, that nothing has been lost by following this plan thus far. In the event that the ear continues to discharge in spite of this method of operating upon it, a radical mastoid, if required later, is made easier to do by the steps already taken.

#### CONCLUSIONS.

1. That many suppurating chronic ears of adult life originate during the contagious diseases of childhood, and cause as much serious trouble in later life as any of the sequelae.
2. A great deal of attention is paid to the general condition (heart, lungs, kidneys, etc.) and little to an otitis media after the acute stage has passed, unless fulminating mastoiditis develops.
3. That these long-discharging ears, except in measles, are a source of spreading disease and require prolonged isolation, and unnecessary expense to the municipal hospitals.
4. That in many cases of middle ear disease in the exanthemata, the destruction and damage does not result in the first few days, but takes place slowly from a neglected discharge that persists because infection continues unrelieved in the adenoid and tonsils, or mastoid antrum and cells.
5. That the simple mastoid operation in these children is not a formidable procedure, and the public should be taught that it is a measure required to save hearing as well as life. It should be termed "post-aural incision" instead of "mastoid" to allay the public fear in case of children.
6. That most of the infection is located in the adenoid and tonsils (not in sinuses) and these should be removed routinely, after infection with contagious disease has passed, if not during the disease.
7. That the type of conservative surgery outlined in this paper causes no damage and paves the way for radical operation, should that prove necessary at a later date.

# THE RHODE ISLAND MEDICAL JOURNAL

Owned and Published by the Rhode Island Medical Society  
Issued Monthly under the direction of the Publication Committee

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Advertising matter must be received by the 10th of the month preceding date of issue.

Advertising rates furnished upon application, to the business manager, B. H. Buxton, M. D., 133 Waterman Street, Providence, R. I.

Reprints will be furnished at the following prices, providing a request for same is made at time proof is returned: 100, 4 pages without covers, \$6.00; each additional 100, \$1.00. 100, 8 pages, without covers, \$7.50; each additional 100, \$2.80; 100, with covers, \$12.00; each additional 100, \$4.80. 100, 16 pages, without covers, \$10.50; each additional 100, \$3.00; 100, with covers, \$16.00, each additional 100, \$5.50.

SUBSCRIPTION PRICE, \$2.00 PER ANNUM. SINGLE COPIES, 25 CENTS.

Entered at Providence, R. I. Post Office as Second-class Matter.

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## EDITORIALS

### PREMEDICATED ALCOHOL.

To define premedicated alcohol, it is only necessary to say that it must contain, upon leaving the distillery, enough of some ingredient (presumably medicinal) that enters into the finished medicinal preparation, as to render it unfit for beverage purposes; after this has been done, alcohol becomes tax free.

It has been whispered somewhat loudly in the ear of the Secretary of the Treasury and the pro-

hibition officials at Washington in the voice said to be that of the general counsel for certain proprietary medicines (?) and by others in the same train of affairs, that the premedication of alcohol is altogether desirable. Why is it desirable?

We bear in mind that in seeking the criminal in a case of homicide, the law propounds the question: "Who profits by this man's death?"

Who profits by the premedication of alcohol? It is not the druggist, who having been trained in making his preparations by formula is not only forced to carry gallons upon gallons of various

medications (much of which must remain for months dead stock) but adds to his confusion and possible uncertainty in compounding.

It is not the doctor, living, perhaps, remote from urban conveniences and making many of his own tinctures and solutions.

It is not the government, who loses millions in revenue and who must also place skilled chemists in every distillery in the country that distributes premedicated alcohol—or leave the matter in the hands of the hired men of this institution to manipulate with what accuracy future vital statistics may be able to testify. At least there must be some method of control.

It is not the gullible and guzzling public, though it may be led to believe that "Mother Shallowitz' Purely Vegetable Compound" or "Old Captain Verboten's Strength-Giving Elixir of Plum Duff" may be bought for less money—because if this belief is entertained, we may all cheerfully subscribe to the time-worn but suspected belief that "Barnum was right."

The cause of prohibition will scarcely be affected with or without premedication. The analysis is then, that the government loses millions in revenue, plus the vast expense of trained experts in possibly separated areas, or face the unthinkable alternative of leaving the premedication to others; the doctor loses because he will scarcely dare trust the preparation or will care to carry so many medications.

The druggist loses because of his added care and additional stock which, possibly, he can ill afford to carry; or he may be able and willing to so select his premedicated stock that by chemical manipulation it will be possible to throw out the medicant and reclaim the alcohol—in which case the law has met defeat.

The only profit that can possibly accrue will therefore be to the commercial enterprises that have never been benefactors but will be further permitted to, like a parasite, thrive and fatten by reason of a vicious law.

If, however, the proposition should become a law and this law respected, it is entirely reasonable to conclude that our present books on pharmacy will either need to be rewritten, retaught and redigested or stand condemned as being only of historic interest.

#### THE RURAL MEDICAL PROBLEM.

Fortunately Rhode Island, because of its small size, is not so keenly interested in this problem as most of the other States, but in many it is a real problem and one that is still far from settlement. It is not apparently due to any shortage of physicians, because, in spite of the reduction in number of medical schools and in the advancing educational qualifications, the number of students studying in the medical schools shows a steady increase.

The principal reason for the problem is the present method of medical education. In the schools of today the students are taught to rely so much on the mechanical and laboratory aids in diagnosis and on the hospital for treatment. After serving an internship in a hospital where pathological, roentgenological, chemical and physiological laboratories play a necessary part in the routine examination of the patient, the conscientious medical practitioner will hesitate before settling in a community where such aids cannot be utilized.

The automobile and the good roads have made communication with the larger centers so easy that many physicians find that their patients are very apt to desert them for the city specialist or for the hospital that furnishes the necessary aids for diagnosis and treatment. The result of this is that either the medical man packs up his belongings to enter the larger field or else he sits back content to do the chore work in medicine, which brings in some return financially, but very little medical satisfaction.

One of the remedies suggested, the subsidization of the physician by the community, will never solve the problem. The average medical man prides himself on his freedom and to be forced to conduct himself against his better judgment would be most humiliating. Another remedy contains more promise and that is the establishment of county hospitals that may act as centers of medical knowledge, where the physician may find the scientific tools to which he has become accustomed and where the patient will receive the proper treatment.

#### THE BEST POLICY.

To tell the "truth, the whole truth, and nothing but the truth" when off the witness stand is not a policy that can invariably be followed by the prac-

titioner of medicine, an eminent colleague in a neighboring city to the contrary notwithstanding. Absolute truth-telling is, however, the ideal at which the practitioner should aim. If human nature were without frailties and human courage were perfect, plain truth would be the golden rule. But when courage is lacking and fear, the *bete noir* of the Eddyite, lurks in the wings, awaiting only as the cue the word of unvarnished truth ere it takes the very center of the stage—when, in other words, only ignorance of the truth prevents panic, let the doctor beware. Under such circumstances to blurt out the cruel facts is to commit a crime. It is atropine in glaucoma.

If, however, knowledge of the truth will not positively harm the patient, it is the duty of the doctor to the best of his ability to impart it. The day of mystery in medicine is over. We no longer look wise, prepare peculiar pills and potions, write mysterious, supposedly Latin words and queer symbols on prescription blanks, and satisfy the patient with long and quite unintelligible names when he asks us what his trouble really is, but we put the truth as we see it into simple language, not trying to conceal those aspects of the case which may be puzzling to us. Thus we gain his confidence and co-operation based on a reasonable conception of what we are about. It is by such straightforward dealing that public trust in the medical profession is fostered. It is true that very often the optimistic side of the truth must be stressed to bolster up courage that is wavering; also at times the warning note must be sharply sounded to curb the enthusiasm of him who would too freely risk his welfare. Nevertheless we deal strictly with demonstrable facts. Thus, gradually, the public is learning the basis, the extent and the limitations of the science and art of medicine. A general knowledge of these things will mark the end of charlatanism inside as well as outside the profession.

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#### LETTER TO THE EDITOR.

#### "OLD TIMES."

Dear Editor:

Your "Lavender Corner" invites in a friendly way to sit by the pleasant fireside while revery calls to memory reminiscences of other days.

On a Christmas of some years ago (1892), my friend of Shrewsbury, Mass., sent me a book en-

titled, "Old Times in Shrewsbury," giving a history of that town from early Colonial days, where he and his forbears practiced medicine for three generations. On the first leaf he had written,

"All things are baubles, beside  
Old wood to burn,  
Old wine to drink,  
Old friends to talk with, and  
Old books to read."

Having now passed my "three score years and ten," and "by reason of strength" entered that uncertain period of "four score," which the Good Book, continuing, adds "yet is their strength, labor and sorrow, for it is soon cut off and we fly away," I am now ready to admit what was not so apparent thirty years ago, when my friend made the statement that this life is a good deal of a bauble, and "we spend our years as a tale that is told." But now "Old wood to burn" at \$18 a cord is hard to get, the "Old wine" impossible, and our "Old friends," when we reach the "sere and yellow leaf," have long since ceased to talk with us, and are passed to their glorious reward; yet we still have left to us the good "Old books to read" and memories, fond and otherwise, of "Old Times."

When I came to this State, the examination of candidates for license to practice medicine in Rhode Island, and for membership in the Medical Society was held before a Board of Censors in old Franklin Hall, North Main Street. A member of this Board, Dr. Ely, asked me to read my Latin diploma (Harvard). I was then requested by another member to consider a case:

The patient came to the doctor's office that morning, from a neighboring city, a young woman, age 20, daughter of a clergyman, graduate of a college, unmarried, now teaching school; complained of a cough, but was more alarmed about the enlargement of her abdomen, which began about six months ago; was now increasing in weight, good appetite, but some nausea mornings, was constipated, and had not menstruated for some time, but this always had been quite irregular, and her physical development had been late in maturing. "What is the diagnosis?" Consumption, imperforate hymen, ascites, tumor, fibroid uterus, pregnancy, intestinal indigestion with flatulence, or phantom tumor? My answer did me no credit, and I am still uncertain of its intent and

the impression made on the examining Board. This case presented problems not lightly to be considered, nor likely to be solved by any snap judgment, on the other hand requiring careful investigation and a critical study of the history; the question given perhaps to test how far inexperience would commit itself, in other words, what medical students call a "catch question"; taking that view accounts for the following trifling reply, "Gentlemen, as her troubles began when tender buds swell in the spring, I should call it a case of misplaced confidence, and where the patient did not with prudence 'keep off the grass.'" My questioner deliberately shook his head, replying, "Young man, always give these patients the benefit of the doubt."

But bear in mind, kind friend, this happening occurred in "Old Times," before the building of the temple on the hill, before Mother Eddy wrote her book, while she was still a helper of Dr. Quimby in Portland. In this modern day some might give quite a different solution of this problem; just a "state of mind," let her forget it, banish these bad thoughts, or mayhap some naughty neighbor has with malicious or malignant thought assailed her; let these evil thoughts be cast out, as were the devils of old, to be followed with absent treatment, properly applied by those skilled in the "cult," at so much per.

But "to return to our mutton"; examination on diphtheria was taken up and I was asked, "When would you do tracheotomy?" My answer was "Never again." Within the month I had passed through the ordeal and met my Waterloo; at night cut a child's throat that was dying, and for the next four days and nights, spent most of the time at that bedside with a feather and by other means, endeavoring to keep the tube patent, that air might reach the lungs, and finally brought to a close one of the horrors of my life, by signing the death certificate. (This, we are reminded, was before the days of antitoxin or intubation.) After the oral there followed a written examination, the conclusion to which proved satisfactory, as subsequently shown by reference to the old records, where we find the following entry:

"Sept. 18, 1884. The quarterly meeting of the R. I. Medical Society. President, Oliver C. Wiggin; Sec., George D. Hersey; Treas., Charles H. Leonard.

"The Board of Censors, Ariel Ballou, J. H. Eldredge, J. W. C. Ely, G. P. Baker, S. S. Keene, Benjamin Greene, E. T. Caswell, Eugene Kingman, recommended Dr. G. E. Buxton of Pawtucket and Dr. F. A. Payan of Olneyville, and these were elected Fellows of the R. I. Medical Society."

As we call to mind these familiar names, the duties and functions performed by these most worthy medical men, and when we are reminded that all those mentioned are dead with one gratifying exception, Dr. Leonard, are we not justified in the term used in our introduction, "Old Times"?

G. EDWARD BUXTON.

To the Editor:

The letter from F. T. R. published in the April issue of THE RHODE ISLAND MEDICAL JOURNAL is interesting and amusing insofar as it shows to what extent a man of reputed intelligence can distort facts and also because its contents could have been written before beginning the trip, given the prejudice he seems to have. But it appears more than prejudice to the writer; it is a regular obsession which disturbs his mind and produces even physical discomfort. No wonder that he has seen everything through a black cloud, has been annoyed by trifles, and has found fault with everything and everybody everywhere he has been in his rapid voyage. The first sign of derangement can be detected on board the S. S. Adriatic when he reflects deeply on human miseries and weakness and is assailed by pseudo-philosophical thoughts. These thoughts work him gradually up to a high pitch of mental excitement, becoming real torture when he arrives at Genoa. He cannot see the blue skies nor feel the effects of the balmy atmosphere of the Riviera, but has a terrible chill all over, becomes very gloomy and starts for the cemetery, from which he returns to resume his trip to Naples. Here he condemns the sky, the scenery, and, what is most incredible, the spaghetti, a fact which constitutes a true calamity to poor Italy. Of Pompeii, of Vesuvius, he says not a word! I can imagine with apprehension what will become of Rome, Florence, Bologna, Milan, Venice, Pisa, Turin, after he has visited them on his return from the land of Pharaohs.

It is evident that F. T. R. passed through Italy with his tourist guide-book under his arm, fully

convinced that with its aid it would be easy for him to pass judgment on such an insignificant country.

My best advice to F. T. R. is to study little history and remain at home. If he decides to cease wandering through the world he should ask frequent advice of his congenial lady acquaintance who, with the characteristic arrogance which comes from the lack of brain, heart, and serious education, said: "I would give more for my sitting room at home and a good fire than I would give for the whole of Italy."

Let us hope, however, that at the Nile, before the Pyramids, F. T. R. will receive worthy inspirations from a great Past, and return quickly to his normal condition.

Providence, R. I.

V. L. RAIA.

THE RHODE ISLAND MEDICAL JOURNAL does not concede itself a court of forensic or any other form of debate; this letter is published by special request.—Ed.

### ANNOUNCEMENT

The Rhode Island Hospital, a charity, public in its service and usefulness but private in its support and management, has depended and must depend on the generosity of the public for the greater part of its maintenance. The cost of caring for the sick and injured has increased so much in recent years that the Board of Trustees has decided, beginning May 1, 1922, to increase the charge for caring for ward patients from \$2.50 per day to \$3.00 per day, even though this new rate does not cover the actual cost per diem, of \$3.72, during the last year. This cost does not include the services of the physicians and surgeons, who give their time and skill gratuitously to the care of ward patients. The Board of Trustees has also decided on the same date to increase the charge for caring for patients in semi-private rooms from \$3.50 per day to \$4.00 per day.

JOHN M. PETERS, M.D., *Superintendent.*

### CASE REPORT

#### A RESUME OF AN UNUSUAL CASE OF CARCINOMA OF THE PANCREAS.

G. W. WELLS, M.D.

PROVIDENCE, R. I.

The case I am reporting tonight was admitted to the Rhode Island Hospital January 5, 1921, on the service of Dr. Frank T. Fulton.

Patient was a silversmith by trade, age 67 years, born in England.

**CHIEF COMPLAINT**—A constant, dull, gnawing, boring pain in the epigastrium of twelve weeks duration.

The pain grew progressively worse after onset, which was insidious. Pain did not radiate, was present continuously and was worse after meals. The patient belched gas occasionally, felt nauseated but never vomited. Was never jaundiced. Had been markedly constipated. He complained of thirst, had taken only liquid food for one week previous to admission because of discomfort in epigastrium caused by solid foods. Had lost about 20 pounds in weight, and felt very weak, which patient believed due to lack of food and sleep.

**Urinary symptoms:** Voided small amounts four or five times at night.

**PAST HISTORY**—Three years before admission became markedly constipated, lumbago one year ago. Lues and Neisser infections denied by name, sign and symptom.

**FAMILY HISTORY**—Unimportant as far as remembered.

**PHYSICAL ON ADMISSION**—Elderly, poorly nourished man lying quietly in bed. Looked acutely ill. Chest: Barrel shaped—ribs and sternum moved as one piece. Expansion equal and fairly good. Fremitus normal, percussion note dull and high pitched; breath sounds blowing and high pitched, occasional sonorous rale.

Heart: No precordial bulging. No visible or palpable apex beat, no thrills. Left border is within nipple line. Right border not defined. Rather marked arrhythmia, no pulse deficit at wrist. No murmurs. Abdomen: Scaphoid in appearance. No scars. Tenderness over epigastrium. Mass in epigastrium very slightly to left of mid line, size of large marble, rather firm and smooth and gives one an impression of pulsating synchronously with the cardiac systole. Dull to percussion, did not move on respiration. Palpation increased the pain in epigastrium but the mass was not tender.

His condition in hospital grew steadily worse, resulting in death 86 days after admission.

Twenty days before death examination of abdomen revealed another palpable mass slightly to right of mid line of epigastrium, firm, size of an egg, and also a larger mass smooth, less firm, size

of a large orange, movable on inspiration, over right kidney region. These masses seemed to be connected with the liver, and persisted with no change until death.

Three days before death his temperature, pulse and respiration rose and he showed typical signs of consolidation in right lung. The following work was carried out during the course of his stay in the hospital:

January 6, 1921: Negative K. L. Renal function 40% at end of two hours. Wassermann negative. Van Slyke, 66 vol. %. White blood count 9,500. X-Ray of gastro-intestinal tract negative.

Blood chemistry 50 mgm. urea per 100 c. c. blood; .07% sugar. Gastric analysis: Before and after test meal within normal limits. No lactic acid. No Boas-Oppler bacilli.

Urine: Specific gravity 10.11. Least possible trace of albumen. Few white blood cells. Few red blood cells. No casts.

Blood pressure 155/95. Weight 129 pounds. January 21. Hyper glycemia for sugar tolerance. Specimen I., 13% sugar; II., 18% sugar; III., 16% sugar. January 26. Provocative Salvarsan given. January 31. Wassermann negative. Blood sugar 14% sugar; 45 mgm. urea per 100 c. c. blood.

February 10. Spinal fluid examination showed 2 cells per cu. mm. Albumen very slight trace. Globulin negative. Wassermann negative. Colloidal gold 0012100000. Blood Wassermann negative.

March 21. W. B. C. 11,400, R. B. C. 3,840,000, Hgb. 65% color index 84. Urine examination showed occasionally slight traces of albumen and shortly after admission, sugar.

Twenty-five days after admission, patient showed sugar for five days, following which he showed sugar in urine only at intervals of five to seven days.

#### PATHOLOGICAL REPORT.

Body is that of an emaciated, old, tall, white man with marked pallor of skin. Fat and muscle tissue poorly developed.

Chest. Left pleural cavity free. Left lung well retracted. Right pleural cavity partly obliterated with loose recently formed adhesions. Right lung partially covered with fibro-purulent exudate.

Abdomen. No free fluid. Liver projects in mamillary line about one finger width below costal arch. Gall bladder markedly distended. Fibro-purulent exudate below the right diaphragm and in the adjoining parts of the peritoneum.

Heart shows a thickened mitral valve with no recent vegetations. Heart weighs 330 gms. Myocardium of rather dark color. Left heart somewhat dilated. Atheromatous changes in coronary artery and quite marked fibrous changes in myocardium.

Left lung weighs 320 gms. Well aerated without macroscopically visible focal lesions. Right lung weighs 1,020 gms. It is heavy and shows an intense lobar infiltration of the upper and middle lobes corresponding to the stage of gray hepatization. A similar area of pneumonic infiltration appears in the lower lobe surrounding a hemorrhagic area which protrudes on the pleural surface of the base and is apparently an area of broken down tissue through which the infection of the right pleural cavity took place. In this region fibro-purulent flakes cover the costal and pleuric surfaces well extending downward into the costal phrenic sinus.

The abdominal cavity shows a tumor situated slightly to the left of the median line and three fingers width above the umbilicus. The stomach is dilated and its greater curvature reaches as far as three fingers below the umbilicus. The stomach, however, merely overlies the tumor and is not involved. The tumor mass is firm, of about the size of a peach and lies between the limbs of the duodenal loop, but does not penetrate into the intestine; neither is it found to be in relation with the abdominal aorta, which, however, shows marked atheromatous changes.

The pancreas head approaches the tumor mass and its tissue seems to be lost in it. Liver weighs 2,400 gms. It is enlarged and shows numerous smaller and larger metastatic nodules of grayish-white tissue. One particular solid and extensive mass of this tissue occupies the under surface of the liver about the region of the transverse fissure. Sections are taken from this part as well as from the tumor mass joining the pancreas head. Cross sections through liver tissue show numerous metastatic nodules of smaller and larger size throughout the substance of the liver. Gall bladder much distended and contains about 200 cc. of mucous, light colored fluid. Cystic duct obliterated.

Kidneys of about normal size. Capsule slightly adherent. No marked changes. Right kidney weighs 230 gms. Left kidney weighs 350 gms.

Pathological diagnosis: Carcinoma of either pancreas head (?) or of hepatic duct (?). Lobar pneumonia of upper and middle lobes of right lung. Fibro-purulent pleurisy. Subphrenic abscess.

### SOCIETY MEETINGS

#### PROVIDENCE MEDICAL ASSOCIATION.

The regular monthly meeting of the Providence Medical Association was called to order by Vice-President W. B. Cutts at 8:50 P. M. on April 3, 1922. The records of the last meeting were read and approved. The Standing Committee having approved the following applications for membership, the Secretary was empowered to cast one ballot for the election of these men: Robert M. Lord, Albert C. Maynard, Malford Wilcox Thewlis, Yacomb T. Touzjian.

Dr. Philemon E. Truesdale of Fall River, Mass., read a paper on "Cancer of the Stomach." The tone of Dr. Truesdale's paper as a whole was rather despairing. This condition, more common than breast cancer, is at present impossible of diagnosis in incipiency and only one in six of the cases found have a chance from treatment. It is a case of late warning, late recognition, and late treatment. He stressed the importance of closer co-operation between medical and surgical men as offering now the best chance of improvement in solving this problem. The paper was discussed by Drs. Matteson, Jones, Mowry, Gerber and Truesdale. Dr. Roy Blosser read a tense clear paper on "Diagnosis of Diseases of the Scalp." Meeting adjourned at 10:15 P. M. Attendance, fifty-eight members. Collation was served.

Monthly meeting held Monday, May 1, 1922, at Rhode Island Medical Society Library, Francis Street, at 8:30 p. m.

Program: Symposium on oral sepsis. Presentation from dental standpoint by Dr. C. A. Brackett, Professor of Oral Pathology, Dental Department, Harvard University; Dr. Percy R. Howe, Assistant Professor Dental Research, Harvard University. Discussion by Dr. A. M. Potter, Providence, R. I., and Dr. Mark Tishler, Providence, R. I.

The Standing Committee approved the application of Albert H. Jackvony, M.D.

Collation followed.

PETER PINEO CHASE, M.D.,  
*Secretary.*

#### RHODE ISLAND MEDICO-LEGAL SOCIETY.

Regular quarterly meeting of the Rhode Island Medico-Legal Society was held at the Medical Library, April 27, 1922, at 5:15 P. M.

Meeting was called to order by the President, Roswell S. Wilcox, M.D. Minutes of preceding meeting were read and approved. Treasurer's report showing balance \$176.06 was read and ordered inserted in the records.

Resignation of Everard Appleton as member of this Society was read and on motion the same was accepted.

The President introduced Rev. John E. Blake, Chaplain of the State Institutions at Howard, who gave a most interesting address, subject, "A Leaf from a Chaplain's Notebook."

On motion, a rising vote of thanks was tendered the speaker. Adjourned at 6:15. Collation followed.

H. S. FLYNN, *Secretary*

#### RHODE ISLAND OPHTHALMOLOGICAL AND OTOLOGICAL SOCIETY.

The regular bi-monthly meeting of the Rhode Island Ophthalmological and Otological Society was held in the Rhode Island Medical Library, April 13th, at 8:30 o'clock.

The program of the evening consisted of a presentation of a case of cyclitis, by Dr. V. Raia; case of exophoria, cured by operation, by Dr. Messinger; paper on "Glaucoma," by Dr. McCabe, and a paper on "Nasal Sinusitis," by Dr. Abbott.

The meeting adjourned at 11 o'clock.

J. L. DOWLING, M.D., *Secretary*

#### WASHINGTON COUNTY MEDICAL SOCIETY.

Quarterly meeting of the Washington County Medical Society was held at the Elm Tree Inn, Westerly, Thursday, April 13, 1922.

After the transaction of routine business, Dr. Richardson of the Providence City Hospital addressed the meeting, taking for his subject, "The Schick Test and Immunity from Diphtheria."

Dinner at the Inn followed adjournment.

W. A. HILLARD, M.D.,  
*Secretary.*

**SECTION IN MEDICINE.**

A regular meeting of the Section in Medicine was held in the Medical Library Tuesday, March 28th, 1922, at 8:45 P. M. Dr. Lloyd T. Brown of the Harvard Medical School gave one of the most interesting talks that has been heard before the Section in some time. Dr. Brown demonstrated many "Faulty Postures" with a large number of photos. The discussion of Dr. Brown's paper followed by Drs. Hammond, Mathews, Mowry, Gray, White and others.

A regular meeting of the Section in Medicine was held Tuesday evening, April 25th, 1922, at 8:30 o'clock at the Medical Library. Papers were presented from the R. I. Hospital by Drs. Chambers, Wells, Melvin and McCarthy. These very interesting papers were discussed by the Visiting Staff of the Hospital as follows: Drs. Sanborn, Mowry, Gerber, Burgess, C. O. Cooke, McDonald, Berry, Wescott, Turner and Gray.

CREIGHTON W. SKELTON, *Sec.*

**HOSPITALS****NEWPORT HOSPITAL.**

April meeting of the staff of Newport Hospital was an open meeting at which the following papers were read by members of the Medical Staff: Classification of "Diseases of the Heart," by Dr. E. V. Murphy; "Mitral Stenosis," by Dr. J. A. Young; "Syphilitic Aortitis," by Dr. N. M. MacLeod.

N. M. MACLEOD, *Secretary*

**BOOK REVIEW**

There comes to the reviewer's table a book, welcomed and esteemed, an old friend in a new and attractive edition, entitled, "The Celebrated Book on the Physician Himself," the Crowning Edition, by D. W. Cathell, M.D.

This might be called a great-little book, great for the many good things its pages contain, great for the helpfulness and pleasure it has already given in past editions, and no less valuable now to the medical man, who still must meet day by day the problems that beset the way; great for remarkable wisdom, for well seasoned advice, for hints, suggestions, comments and directions, that go far in helping the doctor on the road to success. A good little book, because it does not contain bulky pages so common to medical volumes, but of comfortable, easy handled size, a book not large, yet very satisfying, with every page crammed full of bright gems, that fairly sparkle and scintillate, abounding withal in that essential, common sense.

More than forty years ago we secured this book, one of the earlier editions (the first edition was sold out in a few weeks); our purchase was not an expensive one, but we valued it highly then and do so still; at that time we were making but few additions to our library; it still occupies a place in the reviewer's somewhat crowded collection of 1,500 volumes, many more pretentious in size and appearance, in expensive bindings of leather and gold, but few esteemed more highly for their intrinsic worth. It belonged to the limited bookshelves of early days, with no five-foot shelves by experts recommended, but among the few, occupied by school books and standard medical works, was one shelf apart, and grouped upon it by themselves, the Bible, Shakespeare, Pilgrims' Progress, Les Misérables, Autocrat of the Breakfast Table, Ik Marvel's Reveries of a Bachelor, The Luck of Roaring Camp, Innocence Abroad, and with this company was placed The Physician Himself, and this last named came to be one often consulted, valued most highly, and finally considered as guide, councillor and friend, for in this modest and unpretentious book was found answer and solution to the many annoying and perplexing questions that frequently arose.

G. E. B.